

RETURN FORMS TO THE OLDE TOWNE YOUTH CENTER OR ACTIVITY CENTER

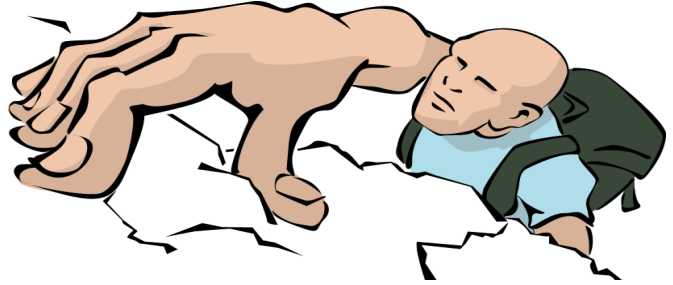
# ANNAPOLIS ROCK

**Monday, July 8, 2019**

**9:00am - 3:00pm**

**Departure Time: 9:15am**

\*The Center will not be open or staffed for the trip before 9:00am.  
Please arrive on time. The trip returns at 3:00pm, but the Center  
will be open until 6:00pm if members want to stay.



**Depart from/Return to**  
**Olde Towne Youth Center**  
**301 Teachers Way**  
**Gaithersburg, MD 20877**

**\$10**

**GYC & Student Union (Grades 6-12)**

Questions? Contact Maura Dinwiddie  
301-258-6440 (Youth Center) or 301-258-6350 (office)  
301-948-8364 (fax)  
yc-oldetowne@gaithersburgmd.gov



Wear comfortable clothing & close-toed  
athletic/hiking shoes. Hiking trails may be  
strenuous. Bring water & lunch/snacks.  
Optional bagged lunch will be provided.

## GYC & Student Union - Hiking Trip to Annapolis Rock 7/8/19 # 8710

Parent's Last Name \_\_\_\_\_ Parent's First Name \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ City Resident ☐ Nonresident ☐  
Email \_\_\_\_\_

Participant's Name	M/F	Birthdate	Activity	Location	Grade	School
			Annapolis Rock	OTYC		
			Annapolis Rock	OTYC		

I hereby grant permission for me/my child to attend the activity sponsored by the City of Gaithersburg. I understand that I am responsible for my/my child's insurance in case of injury. Furthermore, I understand that although safety precautions will be observed, the City of Gaithersburg, employees and agents will not be responsible for any personal property lost by me/my child or any injury sustained in the program. I also consent to the City's use of any photographs and/or video tapes made of the program.

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Signature of Parent/Guardian

Does your child have any allergies, medications or conditions that may affect participation in the program? **Y** ☐ **N** ☐  
Please specify: \_\_\_\_\_

The City of Gaithersburg is committed to making reasonable accommodations as required by the Americans with Disabilities Act. Requests must be made at least three weeks prior to the start of the program. Call 301-258-6350 to indicate what accommodations are needed.

Amount Paid \$ \_\_\_\_\_ Cash ☐ Check # \_\_\_\_\_  
Visa/MC/Disc/Amex# \_\_\_\_\_ Exp. \_\_\_\_/\_\_\_\_  
Signature (name on card) \_\_\_\_\_  
Print Name \_\_\_\_\_

### Office Use Only: 8710

Rec'd: \_\_\_\_\_ Initials \_\_\_\_\_  
W P M F Resident: Y N  
Pr: \_\_\_\_\_ Date: \_\_\_\_\_